COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

DEPARTMENTAL SERVICE ORDER (DSO) REQUEST

FY _____-_____

CONTROL CENTER NAME: _____

CONTROL CENTER NUMBER: _____

Requested by: _____ Date: _____

Approved by: _____ Date: _____
(District/Division Chief or above)

Description of Service:

_____

_____

_____

Purpose of Service:

_____

_____

Approximate Cost:

Salaries & EB	$ _____
Services & Supplies	$ _____
Total	$ _____

BUDGETED: Yes ☐ No ☐ If no, how do you propose to pay for DSO? (Form 402 is necessary if the DSO is not budgeted):

_____

_____

_____

Budget Division Approval _____ Date _____

Accounting Division Processed by _____ Date _____

DSO # _____

c: Budget Services Division
Requestor